MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 22990

Registered No.

1. PLACE OF DEATH
County North
Township Union
City (No. , St. Ward)
Registration District No. 904
Primary Registration District No. 6215

2. FULL NAME Leroy Schoonover Carr

(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Rosa Carr.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 28-1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	65	6	11	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co. Pa.

FATHER
13. NAME James F. Carr
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

MOTHER
15. MAIDEN NAME Schoonover
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

17. INFORMANT (ADDRESS) Roy H. Carr Skidmore Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Isadora DATE June 11, 1934

19. UNDERTAKER (ADDRESS) Long & Bond Skidmore Mo.

20. FILED June 11 1934 Myrtle A. H. Bond Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9- 1934

22. I HEREBY CERTIFY, That I attended deceased from June 8- 1934, to June 9- 1934
I last saw him alive on June 8- 1934 Death is said to have occurred on the date stated above, at 1:30 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Ruptured Abscess of L. Chest	

Other contributory causes of importance:
Intestinal indigestion

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury — , 19....
Where did injury occur? —
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury —
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) T. K. Phipps, M. D.
(Address) Grand City, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

#2

Worth

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON 22990

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Deray Schoonover Carr

Who died at ______ on June 9 - 1934

Residence: No. ______ St. ______ (If nonresident, city or town)

Length of residence in city or town where death occurred: Years ______ Months ______ Days ______

Sex M Color or race W ~~Single~~, married, ~~widowed or divorced:~~ ______

Date of birth ______ Age: Years 65 Months 6 Days 11

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

______

Date deceased last worked at this occupation: Month ______ Year ______

Birthplace (State or country) ______

Birthplace of father (State or country) ______

Birthplace of mother (State or country) ______

Principal cause of death: Ruptured abscess of L. chest / Malignant abscess. / Result of being injured by a horse / some months previous to death. / No other information available

Other contributory causes of importance Intestinal indigestion 188

Name of operation ______ Date of ______

What test confirmed diagnosis? ______ Was there an autopsy? ______

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ______ Date of injury ______, 19__

Where did injury occur? ______ (Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

______

Manner of injury ______

Nature of injury ______

Was disease or injury in any way related to occupation of deceased? ______

If so, specify ______

Name of physician J. T. Phipps

Address of physician Grant City Mo.

Signature of Registrar Mrs O. H. Bond Date filed June 11-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh

State Registrar

Special Agent.

Reg. Dist. No. 904

Primary Reg. Dist. No. 6215

S-22990